**Directly Observed Therapy Log (DOT): 12-Dose Isoniazid-Rifapentine (3HP) LTBI Treatment**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pt. MRN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_ Sex: ☐M ☐F

**Dose**: INH \_\_\_\_\_\_mg., Tab strength \_\_\_\_\_\_\_, INH # tabs \_\_\_\_\_\_ **Dose**: RPT (rifapentine) \_\_\_\_\_\_mg., Tab strength 150 mg., RPT # tabs \_\_\_\_\_\_

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Form developed by: Clackamas County, OR, Public Health Division, Infectious Disease Control and Prevention Program

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| **\*For events listed below, check if event/symptom occurs, otherwise leave blank. (The event may have occurred in the past, after a previous dose)** |
| Date: Dose:  | \_\_/\_\_/\_\_1 | \_\_/\_\_/\_\_2 | \_\_/\_\_/\_\_3 | \_\_/\_\_/\_\_4 | \_\_/\_\_/\_\_5 | \_\_/\_\_/\_\_6 | \_\_/\_\_/\_\_7 | \_\_/\_\_/\_\_8 | \_\_/\_\_/\_\_9 | \_\_/\_\_/\_\_10 | \_\_/\_\_/\_\_11 | \_\_/\_\_/\_\_12 |
| Directly Observed Therapy (DOT) received  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Side Effect/Toxicity – Check in box if present**  |
| **NO adverse reaction** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Loss of appetite  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Nausea or vomiting  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Yellow eyes or skin  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diarrhea  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Rash/hives  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Fever or chills  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sore muscles or joints  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Numbness or tingling  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Fatigue  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dizziness/fainting  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Abdominal pain  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other **(describe in progress note)**  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Tests** – blood work (prn)  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Next Appointment |  |  |  |  |  |  |  |  |  |  |  |  |
| Staff Initials\*\* |  |  |  |  |  |  |  |  |  |  |  |  |
| Patient Signature/Initials |  |  |  |  |  |  |  |  |  |  |  |  |
| **Rx stop or held**  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|  |
| Methadone withdrawal\* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| \* (> 3 new symptoms for > 7 days) nausea and vomiting, abdominal cramps, body aches, restlessness, irritability, dilated pupils, tremors, involuntary twitching, lacrimation,rhinorrhea, sneezing, yawning, excessive perspiration, goose flesh, or diarrhea |
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| \*\*initials |  | signature | initials |  | signature | initials |  | signature | initials |  | signature |
|  |
| Final Disposition: | ☐☐Completed treatment ☐Stopped treatment ☐Adverse event ☐Lost to f/u ☐Moved ☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ |